PF-2006-00690

NOTICE

THIS NOTICE is to advise you that in the event a complaint should arise about this insurance, please contact our Customer Service Department at:

If we at [redacted] fail to provide you with reasonable and adequate service, you should feel free to contact:

California Department of Insurance
Consumer Services Division
300 S. Spring Street, 14th Floor
Los Angeles, CA 90013
800-927-4357 (Inside California)
213-897-8921 (Outside California and Area Codes 213, 310, and 818)
TDD: 800-482-4TDD (4833)

[redacted]

[redacted]

CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION ACT SUMMARY DOCUMENT AND DISCLAIMER

Residents of California who purchase life and health insurance and annuities should know that the insurance companies licensed in this state to write these types of insurance are members of the California Life and Health Insurance Guarantee Association ("CLHIGA"). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guarantee Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided through the Association is not unlimited, as noted in the box below, and is not a substitute for consumers' care in selecting insurers.

The California Life and Health Insurance Guarantee Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. **However, insurance companies and their agents are prohibited by law from using the existence of the Guarantee Association to induce you to purchase any kind of insurance policy.**

Policyholders with additional questions should first contact their insurer or agent or may then contact:

California Life and Health Insurance
Guarantee Association
P.O. Box 17319
Beverly Hills, CA 90209-3319
(213) 782-0182

or

Consumer Service Division
California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357 or (213) 897-8921

The state law that provides for this safety-net coverage is called the California Life and Health Guarantee Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contracts holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits;

LIMITS ON AMOUNTS OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

80% of what the life insurance company would owe under a life policy or annuity contract up to:

- $100,000 in cash surrender values,
- $100,000 in present value of annuities, or
- $250,000 in life insurance death benefits.

A maximum of $250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

- A maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

ISSUING GROUP POLICY NO. {____}

HEREBY AGREES WITH {_____}

(Herein called the Policyholder)

to insure under the Policy Eligible Persons, as defined in the statement entitled "Eligibility" appearing in the application attached hereto, (herein individually called the Insured) and promises to pay for loss resulting from injury or sickness in the manner and to the extent herein provided.

POLICY PERIOD AND PREMIUM CALCULATION

The Policy is dated and takes effect { } and continues in effect as long as the applicable renewal premium according to the attained age of the Insured as stated in the application attached hereto shall be paid as herein agreed; provided, however, that either the Policyholder or the Company may terminate the Policy as of the { } day of { } any year after { } by giving written notice to the other at least 90 days prior to said termination date. The Policy, including premium rates, may be modified by mutual agreement between the Policyholder and the Company. All periods of insurance hereunder shall begin and end at 12:01 A.M., Standard Time, at the business address of the Policyholder.

Premium for the insurance provided by the Policy shall be calculated as stated in the application attached hereto and made a part hereof and is payable in advance. First premiums are due and payable on the effective date of coverage hereunder. Renewal premiums are due and payable { }.

IN WITNESS WHEREOF, the [redacted] has caused the Policy to be signed by its President and Secretary at [redacted]

GROUP DISABILITY INCOME POLICY

[redacted]

DEFINITIONS

"Injury" wherever used in the Policy means bodily injury caused by an accident occurring while the Policy is in force as to the Insured.

"Sickness" wherever used in the Policy means sickness or disease which causes disability covered by the Policy commencing while the Policy is in force as to the Insured.

"Schedule" as used herein means the Schedule contained in the Application attached hereto and made a part hereof.

"Elimination Period" wherever used in the Policy or as stated in the Schedule page means the number of consecutive calendar days the Insured is disabled and prevented from performing the substantial and material duties of his or her occupation before indemnity shall become initially payable.

"Total disability", "totally disabled" or "disability" means that as a result of sickness or injury the Insured is unable to perform with reasonable continuity the substantial and material acts necessary to pursue the Insured's usual occupation in the usual or customary way.

Substantial and material acts means acts that are normally required for the performance of the Insured's usual occupation and cannot be reasonably omitted or modified.

MONTHLY ACCIDENT OR SICKNESS INDEMNITY

Indemnity will not be paid under this part for any period of disability prior to the expiration of the Elimination Period, if any, stated in the Schedule applicable to the Insured. To continue benefits for any period of disability under this part, written proof of loss must be provided to the Company and the Insured must be under the regular care of a currently licensed physician, surgeon, or chiropractor, other than the Insured or a member of his or her family.

When a disability, begins within 30 days after the date of the accident or the first manifestation of sickness and while the Policy is in force as to the Insured, the Company will pay periodically the Monthly Indemnity stated in the Schedule applicable to the Insured for each month the Insured shall be totally disabled, but not to exceed the Maximum Amount of Indemnity Per Period of Disability stated in the Schedule as the result of any one accident or sickness.

Successive periods of disability, due to the same or related causes, not separated by return to active full-time employment for six months or more shall be considered as one period of disability.

Indemnity payable under the Policy for periods of disability which are less than one month will be payable on a pro rata basis calculated at the rate of 1/30 of the applicable Monthly Indemnity stated in the Schedule applicable to the Insured.

WAIVER OF PREMIUM

Upon due proof that total disability of the Insured for which indemnity is payable under the Policy has continued for a six consecutive month period commencing with the expiration of the elimination period, if any, while the Policy is in force as to such Insured, the Company will waive the payment of any premium of such Insured becoming due during any further continuous period of total disability for which indemnity is payable and the Policy shall remain in force as to such Insured until the next premium due date, subject to all its conditions, except as to the payment of premium. Following a period during which the Company has waived the payment of premiums, the Insured shall have the right to resume the payment of premiums as they become due thereafter subject to all the provisions and conditions of the Policy.

ELIGIBILITY AND EFFECTIVE DATE OF INDIVIDUAL INSURANCE

All Eligible Persons who are actively performing the full-time duties of their occupations are eligible to apply for insurance under the Policy. The Company will issue insurance hereunder to such Eligible Persons who make written application for insurance in accordance with the Underwriting Provisions appearing in the Application attached hereto and the insurance hereunder of such Eligible Persons shall take effect on the date of the Company's approval of the written application, but in no event prior to the effective date of the Policy.

No insurance provided by the Policy shall become effective as to an individual Insured unless the applicable first premium has been paid and unless such Insured is actively performing the full-time duties of his or her occupation on the date the insurance of such person would otherwise become effective.

INDIVIDUAL TERMINATIONS

The insurance of any Insured shall terminate on the earliest date any of the following events occur:

(1) On the date the Group Policy is terminated;

(2) As of the premium due date when the required premium is not paid, subject to the grace period;

(3) On the premium due date following the date the Insured retires or voluntarily ceases to be actively performing the full-time duties of his or her occupation;

(4) On the premium due date following the date the Insured ceases to be a Member of the Policyholder;

Termination of the insurance of any Insured shall be without prejudice to any claim originating prior thereto; provided, the Insured remains unable to perform the substantial and material duties of his or her occupation.

INDIVIDUAL CERTIFICATES

The Company will issue for delivery to the Insured, an individual certificate describing the indemnities to which the Insured is entitled under the Policy, to whom payable, the limitations and requirements of the Group Policy pertaining to the Insured and where the Group Policy may be inspected.

EXCLUSIONS

The Policy does not cover any loss, fatal or non-fatal, caused by or resulting from any one or more of the following:

(a) Suicide or intentionally self-inflicted injury or any attempt thereat, while sane or insane (in Missouri while sane);

(b) Declared or undeclared war or any act thereof;

(c) Any loss commencing while the Insured is in the service of the armed forces of any country. Order to active military service for training purposes of two months or less shall not, for the purposes of this exclusion, constitute service in the armed forces of any country. Upon notification to the Company of entering the armed forces of any country, the Company will return to the Insured pro rata any premium paid for any period during which the Insured is in such service;

(d) Abortion;

(e) Flying as a pilot, crew member, or passenger in any aircraft, except as a fare-paying passenger in any regularly scheduled commercial aircraft flying between established airports on a regularly scheduled route;

(f) Injury or sickness for which compensation is payable under any Worker's Compensation Law or sickness for which the Insured is entitled to benefits under any Occupational Disease Law, or "4800" time benefit plan.

GENERAL PROVISIONS

ENTIRE CONTRACT: CHANGES: The Policy, the Application of the Policyholder, if any, and the individual applications, if any, of the Insured, constitute the entire contract between the parties, and any statements made by the Policyholder or by any Insured shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under the Policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void the Policy after it has been in force for three years from the date of its issue, nor shall any such statement of any Insured eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability, as defined in the Policy, commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in the Policy shall be valid unless approved by an executive officer of the Company and unless such approval be endorsed hereon or attached thereto. No agent has authority to change the Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: No claim for loss incurred or disability as defined in the Policy commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name of specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of premiums accruing after the first premium during which grace period the Policy shall continue in force, but the Policyholder shall be liable to the Company for the payment of the premium accruing for the period the Policy continues in force. The termination of the Policy by the Policyholder or by mutual consent, express or implied, of the Policyholder and the Company, effective as of the premium due date or during a period of grace will terminate the period of grace for the payment of premiums as of the date of such termination of the Policy.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Company at [redacted], or to any authorized agent of the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS: The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOFS OF LOSS: Written proof of loss must be furnished to the Company, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, within ninety days after the termination of the period for which the Company is liable, and in case of claim for any other loss, within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Insured, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Subject to due written proof of loss, all indemnities for loss for which the Policy provides payment will be paid to the Insured as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Insured immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: Any accrued indemnities unpaid at the Insured's death may, at the option of the Company, be paid either to the Insured's beneficiary or to the Insured's estate. All other indemnities will be payable to the Insured.

If any indemnity of the Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

PHYSICAL EXAMINATION: The Company at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

CONFORMITY WITH STATE STATUTES: Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy was issued is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: The Company shall not be liable for any loss sustained or contracted in consequence of the person whose injury or sickness is the basis of claim being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

WORKERS' COMPENSATION: The Policy does not replace or affect any requirement for coverage by Workers' Compensation insurance.

The Group Policy is in the possession of the Policyholder and may be inspected by the Insured at any time during business hours at the office of the Policyholder.

BENEFICIARY: Beneficiary means the person or entity named on the Company's records to receive the benefit after the Insured dies. The Insured may name any person as Beneficiary. If two or more Beneficiaries are named, each will receive an equal portion of the benefit, unless the Insured designates otherwise.

The right to change of beneficiary is reserved to the Insured, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

If there is no designated Beneficiary when the Insured dies, the Company will pay the benefits to the first of the following living persons:

1. the Insured's spouse;
2. the Insured's children, equally;
3. the Insured's parents, equally; or
4. the Insured's brothers and sisters, equally.

If none of the above persons is living on the date of the Insured's death, the Company will pay the benefits to the Insured's estate.

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P.O. Box 17319
Beverly Hills, CA 90209-3319
(213) 782-0182

or

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California Department of Insurance
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357 or (213) 897-8921

The state law that provides for this safety-net coverage is called the California Life and Health Guarantee Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Association.

COVERAGE

Generally, individuals will be protected by the California Life and Health Insurance Guarantee Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guarantee Association if:

- Their insurer was not authorized to do business in this state when it issued the policy or contract;
- Their policy was issued by a health care plan (HMO), Blue Cross, Blue Shield, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society;
- They are eligible for protection under the laws of another state. This may occur when the insolvent insurer was incorporated in another state whose guarantee association protects insureds who live outside that state.

The Guarantee Association also does not provide coverage for:

- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which guarantee rights to group contracts holders, not individuals;
- Employer and association plans, to the extent they are self-funded or uninsured;
- Synthetic guaranteed interest contracts;
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance unless an assumption certificate was issued;
- Interest rate yields that exceed an average rate;
- Any portion of a contract that provides dividends or experience rating credits;

LIMITS ON AMOUNTS OF COVERAGE

The Act limits the Association to pay benefits as follows:

LIFE AND ANNUITY BENEFITS

80% of what the life insurance company would owe under a life policy or annuity contract up to:

- $100,000 in cash surrender values,
- $100,000 in present value of annuities, or
- $250,000 in life insurance death benefits.

A maximum of $250,000 for any one insured life no matter how many policies and contracts there were with the same company, even if the policies provided different types of coverages.

HEALTH BENEFITS

- A maximum of $200,000 of the contractual obligations that the health insurance company would owe were it not insolvent. The maximum may increase or decrease annually based upon changes in the health care cost component of the consumer price index.

PREMIUM SURCHARGE

Member insurers are required to recoup assessments paid to the Association by way of a surcharge on premiums charged for health insurance policies to which the Act applies.

Certificate of Insurance issued under the terms of Group Insurance Policy No. { }

insuring the Employees of { }

(Herein called the Policyholder)

HEREBY CERTIFIES that the persons defined in the Schedule (herein individually called the Insured) are insured under and subject to all the provisions, definitions, limitations and conditions of the Group Policy from and after 12:01 A.M., Standard Time, on the Effective Date shown in the Schedule. The insurance of the Insured reflected by this Certificate is further subject to any modification of the Group Policy entered into by mutual agreement between the Company and the Policyholder as of the effective date of such modification.

GROUP DISABILITY INCOME CERTIFICATE

DEFINITIONS

"Injury" wherever used in the Policy means bodily injury caused by an accident occurring while the Policy is in force as to the Insured.

"Sickness" wherever used in the Policy means sickness or disease which causes disability covered by the Policy commencing while the Policy is in force as to the Insured.

"Elimination Period" wherever used in the Policy or as stated in the Schedule Page means the number of consecutive calendar days the Insured is disabled and prevented from performing the substantial and material duties of his or her occupation before indemnity shall become initially payable.

"Total disability", "totally disabled" or "disability" means that as a result of sickness or injury the Insured is unable to perform with reasonable continuity the substantial and material acts necessary to pursue the Insured's usual occupation in the usual or customary way.

Substantial and material acts means acts that are normally required for the performance of the Insured's usual occupation and cannot be reasonably omitted or modified.

MONTHLY ACCIDENT OR SICKNESS INDEMNITY

Indemnity will not be paid under this part for any period of disability prior to the expiration of the Elimination Period, if any, stated in the Schedule applicable to the Insured. To continue benefits for any period of disability under this part, written proof of loss must be provided to the Company and the Insured must be under the regular care of a currently licensed physician, surgeon, or chiropractor, other than the Insured or a member of his or her family.

When a disability, begins within 30 days after the date of the accident or the first manifestation of sickness and while the Policy is in force as to the Insured, the Company will pay periodically the Monthly Indemnity stated in the Schedule applicable to the Insured for each month the Insured shall be totally disabled, but not to exceed the Maximum Amount of Indemnity Per Period of Disability stated in the Schedule as the result of any one accident or sickness.

Successive periods of disability, due to the same or related causes, not separated by return to active full-time employment for six months or more shall be considered as one period of disability.

Indemnity payable under the Policy for periods of disability which are less than one month will be payable on a pro rata basis calculated at the rate of 1/30 of the applicable Monthly Indemnity stated in the Schedule applicable to the Insured.

WAIVER OF PREMIUM

Upon due proof that total disability of the Insured for which indemnity is payable under the Policy has continued for a six consecutive month period commencing with the expiration of the elimination period, if any, while the Policy is in force as to such Insured, the Company will waive the payment of any premium of such Insured becoming due during any further continuous period of total disability for which indemnity is payable and the Policy shall remain in force as to such Insured until the next premium due date, subject to all its conditions, except as to the payment of premium. Following a period during which the Company has waived the payment of premiums, the Insured shall have the right to resume the payment of premiums as they become due thereafter subject to all the provisions and conditions of the Policy.

INDIVIDUAL TERMINATIONS

The insurance of any Insured shall terminate on the earliest date any of the following events occur:

(1) On the date the Group Policy is terminated;

(2) As of the premium due date when the required premium is not paid, subject to the grace period;

(3) On the premium due date following the date the Insured retires or voluntarily ceases to be actively performing the full-time duties of his or her occupation;

(4) On the premium due date following the date the Insured ceases to be a Member of the Policyholder;

Termination of the insurance of any Insured shall be without prejudice to any claim originating prior thereto; provided, the Insured remains unable to perform the substantial and material duties of his or her occupation.

EXCLUSIONS

The Policy does not cover any loss, fatal or non-fatal, caused by or resulting from any one or more of the following:

(a) Suicide or intentionally self-inflicted injury or any attempt thereat, while sane or insane (in Missouri while sane);

(b) Declared or undeclared war or any act thereof;

(c) Any loss commencing while the Insured is in the service of the armed forces of any country. Order to active military service for training purposes of two months or less shall not, for the purposes of this exclusion, constitute service in the armed forces of any country. Upon notification to the Company of entering the armed forces of any country, the Company will return to the Insured pro rata any premium paid for any period during which the Insured is in such service;

(d) Abortion;

(e) Flying as a pilot, crew member, or passenger in any aircraft, except as a fare-paying passenger in any regularly scheduled commercial aircraft flying between established airports on a regularly scheduled route;

(f) Injury or sickness for which compensation is payable under any Workers' Compensation Law or sickness for which the Insured is entitled to benefits under any Occupational Disease Law, or "4800" time benefit plan.

PREMIUM CHANGES AND GROUP POLICY TERMINATION

Either the premiums may be changed or the Group Policy terminated by the Company on any Anniversary Date by providing the Policyholder written notice of such intent at least 90 days prior to said Anniversary Date. The Policyholder may terminate the Group Policy on any Anniversary Date by providing written notice to the Company at least 90 days prior to said termination.

GENERAL PROVISIONS

ENTIRE CONTRACT: CHANGES: The Policy, the Application of the Policyholder, if any, and the individual applications, if any, of the Insured, constitute the entire contract between the parties, and any statements made by the Policyholder or by any Insured shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under the Policy or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used at all to void the Policy after it has been in force for three years from the date of its issue, nor shall any such statement of any Insured eligible for coverage under the Policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability, as defined in the Policy, commencing after the insurance coverage with respect to which claim is made has been in effect for three years from the date it became effective.

No change in the Policy shall be valid unless approved by an executive officer of the Company and unless such approval be endorsed hereon or attached thereto. No agent has authority to change the Policy or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES: No claim for loss incurred or disability as defined in the Policy commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name of specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

GRACE PERIOD: A grace period of 31 days will be granted for the payment of premiums accruing after the first premium during which grace period the Policy shall continue in force, but the Policyholder shall be liable to the Company for the payment of the premium accruing for the period the Policy continues in force. The termination of the Policy by the Policyholder or by mutual consent, express or implied, of the Policyholder and the Company, effective as of the premium due date or during a period of grace will terminate the period of grace for the payment of premiums as of the date of such termination of the Policy.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 30 days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to the Company a[redacted], or to any authorized agent of the Company, with information sufficient to identify the Insured, shall be deemed notice to the Company.

CLAIM FORMS: The Company, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

PROOFS OF LOSS: Written proof of loss must be furnished to the Company, in case of claim for loss for which the Policy provides any periodic payment contingent upon continuing loss, within ninety days after the termination of the period for which the Company is liable, and in case of claim for any other loss, within ninety days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Insured, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIM: Subject to due written proof of loss, all indemnities for loss for which the Policy provides payment will be paid to the Insured as they accrue and any balance remaining unpaid at termination of the period of liability will be paid to the Insured immediately upon receipt of due written proof.

PAYMENT OF CLAIMS: Any accrued indemnities unpaid at the Insured's death may, at the option of the Company, be paid either to the Insured's beneficiary or to the Insured's estate. All other indemnities will be payable to the Insured.

If any indemnity of the Policy shall be payable to the estate of the Insured, or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

PHYSICAL EXAMINATION: The Company at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder.

LEGAL ACTIONS: No action at law or in equity shall be brought to recover on the Policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

CONFORMITY WITH STATE STATUTES: Any provision of the Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Policy was issued is hereby amended to conform to the minimum requirements of such statutes.

INTOXICANTS AND NARCOTICS: The Company shall not be liable for any loss sustained or contracted in consequence of the person whose injury or sickness is the basis of claim being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

WORKERS' COMPENSATION: The Policy does not replace or affect any requirement for coverage by Workers' Compensation insurance.

The Group Policy is in the possession of the Policyholder and may be inspected by the Insured at any time during business hours at the office of the Policyholder.

BENEFICIARY: Beneficiary means the person or entity named on the Company's records to receive the benefit after the Insured dies. The Insured may name any person as Beneficiary. If two or more Beneficiaries are named, each will receive an equal portion of the benefit, unless the Insured designates otherwise.

The right to change of beneficiary is reserved to the Insured, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

If there is no designated Beneficiary when the Insured dies, the Company will pay the benefits to the first of the following living persons:

1. the Insured's spouse;
2. the Insured's children, equally;
3. the Insured's parents, equally; or
4. the Insured's brothers and sisters, equally.

If none of the above persons is living on the date of the Insured's death, the Company will pay the benefits to the Insured's estate.